Lampiran A

HEALTH EXAMINATION
GUIDELINES FOR ENTRY INTO
MALAYSIAN HIGHER EDUCATIONAL INSTITUTIONS

1. PLEASE READ THE INSTRUCTIONS CAREFULLY BEFORE FILLING IN THE FORM.
2. PLEASE FILL IN THE FORM IN **ENGLISH** LANGUAGE.
3. PLEASE WRITE IN **CAPITAL LETTERS**.
4. THIS FORM HAS **4 SECTIONS**:
   (a) SECTION 1 (PART A AND B) TO BE FILLED BY THE APPLICANT; AND
   (b) SECTION 2, 3 AND 4 TO BE FILLED BY THE EXAMINING DOCTOR
5. PLEASE COMPLETE ALL THE TESTS REQUIRED IN THIS FORM.
6. THE UNIVERSITY / COLLEGE ONLY ACCEPTS MEDICAL EXAMINATION DONE WITHIN **60 DAYS** BEFORE REGISTRATION OR WITHIN **30 DAYS** AFTER REGISTRATION.
7. PLEASE ATTACH ALL THE **ORIGINAL** LABORATORY RESULTS.
8. PLEASE BRING ALONG **CHEST X-RAY FILM AND REPORT** FOR REGISTRATION.
9. PLEASE ENSURE THE X-RAY FILM IS **LABELLED** WITH YOUR NAME AND DATE TAKEN (IN ENGLISH).
10. CHEST X-RAY DONE WITHIN **6 MONTHS PRIOR** TO REGISTRATION CAN BE ACCEPTED.
11. THE UNIVERSITY/ COLLEGE RESERVES THE RIGHT TO **REPEAT** FULL MEDICAL CHECK-UP OR ANY SPECIFIC LABORATORY TESTS SHOULD THERE BE ANY DOUBT IN THE MEDICAL REPORT SUBMITTED. ALL COSTS INVOLVED SHALL BE BORNE BY THE CANDIDATES.
12. THE UNIVERSITY/ COLLEGE RESERVE THE RIGHT TO **REJECT** ANY APPLICATION:
    (a) BASED ON THE RESULTS OF THE HEALTH EXAMINATION; OR
    (b) SHOULD THERE BE ANY EVIDENCE THAT THE APPLICANT HAS GIVEN FALSE INFORMATION IN THE HEALTH EXAMINATION REPORT OR ANY SUPPORTING DOCUMENTS.

UNIVERSITI MALAYSIA SABAH
Centre for International Affairs

(Undergraduate / Postgraduate)

HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT AND ACCOMPANYING PERSON

Photo

PLEASE USE CAPITAL LETTERS

SECTION 1 (To be completed by candidate)
(PART A) – * Please tick (√) in the relevant box

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NO.

NATIONALITY

CONTACT NUMBER

DATE OF BIRTH
D D M M Y Y

AGE

SEX*
MALE
FEMALE

MARITAL STATUS*
SINGLE
MARRIED

SEMESTER*
1
2

ACADEMIC YEAR
/

STUDENT ID

LEVEL OF STUDY*
DEGREE
MASTER
MASTER OF PHOLOSOPHY
PHD

MODE OF STUDY*
RESEARCH
COURSEWORK

MODE OF REGISTRATION*
FULL TIME
PART TIME

NEXT OF KIN

NEXT OF KIN'S ADDRESS

NEXT OF KIN'S CONTACT NUMBER

SECTION 1

(PART B) – Please tick (√) in the relevant box

Declaration of self and family illness. Explain in full if you or your family has any of the following illnesses.
* Immediate family refers to father, mother, brothers / sisters

MEDICAL PROBLEMS	SELF		IMMEDIATE FAMILY		If "Yes" please state.
	Yes	No	Yes	No	
1. Congenital or inherited disorder					
2. Allergy					
3. Mental illness					
4. Fits, stroke, other neurological disease					
5. Diabetes Mellitus					
6. Hypertension					
7. Heart or vascular disease					
8. Asthma					
9. Thyroid disease					
10. Kidney disease					
11. Cancer					
12. Tuberculosis					
13. Drug addiction					
14. AIDS, HIV					
15. History of surgery					
16. Other illnesses					

Current medication (Long term)

_______________________________ _______________________________

_______________________________ _______________________________

IMMUNIZATION HISTORY (where applicable)	DATE IMMUNIZED				
1. Yellow Fever					
2. BCG					
3. Meningitis (Quadrivalent)					
4. Hepatitis B					
5. Others:					

I hereby certify that the information given above is true. I understand that my application will be rejected if there is any false information given.

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Date Signature of candidate

SECTION 2 - PHYSICAL EXAMINATION
To be filled by examining doctor

1. BASIC MEASUREMENT	
HEIGHT : ___________________m	BLOOD PRESSURE : _______________mmHg
WEIGHT : ___________________kg	PULSE RATE : _______________/ min
VISION TEST : Unaided : (R) ________(L) __________ Aided : (R) ________(L) __________	COLOUR VISION TEST : NORMAL / ABNORMAL

2. GENERAL EXAMINATION			
ITEM	**YES**	**NO**	**COMMENT**
a. DEFORMITIES			
b. PALLOR			
c. CYANOSIS			
d. JAUNDICE			
e. OEDEMA			
f. SKIN DISEASES			

3. SYSTEMIC EXAMINATION			
ITEM	**NORMAL**	**ABNORMAL**	**COMMENT**
a. EYES (including funduscopy)			
b. EARS			
c. NOSE			
d. ORAL CAVITY / THROAT			
e. NECK			
f. HEART			
g. LUNGS			
h. ABDOMEN / HERNIA ORIFICES			
i. NERVOUS SYSTEM			
j. MENTAL CONDITION			
k. MUSCULOSKELETAL SYSTEM			

SECTION 3 - INVESTIGATIONS

URINE TEST		
ITEM	**DATE TAKEN**	**RESULT**
a. ALBUMIN		
b. SUGAR		
c. MICROSCOPIC		
d. MORPHINE		
e. CANNABIS		
f. AMPHETAMINES TYPE STIMULANT		

BLOOD TEST		
ITEM	**DATE TAKEN**	**RESULT**
a. HEPATITIS Bs ANTIGEN		
b. HEPATITIS C		
c. HIV		
d. VDRL / TPHA		
e. MALARIAL PARASITE		

CHEST X-RAY INFORMATION	
CHEST X-RAY NO.	
DATE TAKEN	
PLACE TAKEN	
REPORT	

SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (√) in the appropriate box

I certify that I have on this date ____________________examined

Mr. / Ms ____________________________________Passport No ______________________

and found him / her:-

☐ IN GOOD HEALTH

☐ HAVING THE FOLLOWING MEDICAL COMPLICATION(S) (Please State)

____

____

____

☐ UNDERGOING TREATMENT FOR: (Please State)

____

____

____

Date ______________

Signature of Doctor : _________________________

Name of Doctor : _________________________

Qualification : _________________________

Hospital / Clinic Registration Number : ____________________

Official stamp : ____________________

Remarks By University/College Official: